operatively. ePAQ is a validated tool to assess pelvic floor symptoms and quality of life, and comprises questions within the domains of urinary, bowel, vaginal and sexual function.
Results: Between May 2010 and May 2012, 36 patients underwent an LVR. Of these, 8 women completed pre- and post-operative ePAQs. We calculated Effect Size (ES) and Standardised Response Mean (SRM) for patient responses and performed comparisons using Students t-test. We found improvements in quality of life in the urinary domain (ES 1.49, SRM 1.8, p 0.05) and the bowel domain (ES 2.1, SRM 1.8, p 0.06). These results did not quite achieve statistical significance, possibly due to the small cohort. However, we did not find deterioration in symptoms within vaginal or sexual domains.
Conclusion: We have shown that LVR has the potential to improve bowel symptoms without causing deterioration in other pelvic floor compartments.

0933: IS LOW HARTMANN'S (LH) A BETTER PROCEDURE THAN LOW ANTERIOR RESECTION (LAR) FOR PATIENTS WITH LOW RECTAL CANCER?

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Aim: To compare surgical outcomes in patients undergoing LH and LAR for low rectal cancer.
Method: Patient details were extracted from a dedicated colorectal cancer database. All patients had histologically proven adenocarcinoma, cancer staging and MDT discussion. Complications were recorded by direct observation of patient records.
Results: Between 2008 and 2012, 10 patients underwent LH (mean age 79.7, SD 5.3). 21 patients underwent LAR (mean age 64.0, SD 11.8). Post-operative wound infections were more frequent in LH group – 40.0% for LH and 4.7% for LAR (OR 13.3 (95% CI 1.2-143.2)). Other complications, length of stay; readmission; return to theatre; ITU admission and ileus were not significantly different. Five patients (23.8%, 95% CI 5.6 – 42.0) in LAR group had anastomotic leak. Intra-abdominal collections complicated 3 patients in LAR group and 4 patients in LH group. No cases of stump blow-out in LH group.
Conclusion: Low anastomosis in LAR may be complicated by anastomotic leak or functional impairment. LH is a suitable option for low rectal cancer patients as it avoids the mortality and morbidity of a low anastomosis. Our study revealed that LH is not without its own complications. Patients need to be aware of this and counselled appropriately.

0967: EFFECTIVE RESECTION OF COMPLEX RECTAL POLYPS BY TRANSANAL ENDOSCOPIC MICROSURGERY OBVIATES THE NEED FOR ABDOMINAL SURGERY – RESULTS FROM THE AMNCH TEMS REGISTRY

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Introduction: Rectal polyps require complete resection to prevent the risk of transformation. Traditional transanal approaches have limitations. Transanal endoscopic microsurgery (TEMS) has transformed the management of middle and high rectal lesions.
Aims: To demonstrate that TEMS is an effective alternate, to an abdominal approach for middle and high rectal lesions.
Method: Retrospective analysis of a prospectively maintained colorectal database. Sub-group analysis of rectal polyps located at or above 8cm.
Results: 196 patients (102 males) underwent TEMS between 1998 and 2012. The number of patients with a lesion above 8cm was 115, including 64 with a lesion 10cm above the anal verge. Median age of 64 years (range 38-87). Fourteen patients required a repeat procedure, with one patient having 3 in total. The majority of lesions were tubulovillous with no severe dysplasia. Thirteen patients required major surgery for the presence of adenocarcinoma. The median length of stay after TEMS was 4 days (range 0-27 days). Complications arose in 18 patients (2.6%), the majority of which were minor complications.
Conclusions: TEMS is a minimally invasive effective alternate for the removal of middle and high rectal polyps in cases where an abdominal approach would have been taken.

0988: FOLLOW-UP STUDY: THE EFFECT OF TATTOOING ON COLORECTAL CANCER LYMPH NODE YIELD

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Aim: Previous studies have shown that preoperative colonoscopic tattooing of malignant lesions may increase the lymph node yield from pathology specimens removed with subsequent surgery. Avoidance of tattooing thus potentially results in downgrading of tumour grade classification. The aim of this study was to further ascertain the effect of preoperative tattooing of bowel cancer lesions on lymph node yield.
Method: A retrospective study was carried out at the Conquest Hospital, Hastings of all elective bowel cancer operations performed between 2008 and 2011.
Results: 232 cases were analysed. These consisted of 100 rectal and 132 colonic cancers.
102 (44%) of the tumours were tattooed preoperatively. The mean lymph node yield of the tattooed and non-tattooed lesions was 17.0 (11 – 15) and 17.5 (10 – 16) respectively (p value 0.33).
72.5% of the tattooed lesions had a lymph node yield of more than 12 in comparison to 71.5% of the non-tattooed lesions.
Conclusion: No significant difference was found for absolute lymph node yields between tattooed and non-tattooed lesions. More evidence is required that tattooing has a significant impact on lymph node yield. However tattooing remains an important and safe technique to aid surgical localisation of tumours particularly for laparoscopic procedures.

1042: RIGID SIGMOIDOSCOPY: A DINOSAUR DIAGNOSTIC TOOL?

Rebecca Griggs, Thomas Cork, Charles Robertson. *Worcester Royal Hospital, Worcester, UK.*
Aim: Rigid sigmoidoscopy is a traditional and routine investigation used in colorectal outpatient clinics to investigate and diagnose colorectal cancer. Flexible sigmoidoscopy and colonoscopy (endoscopy) are often used in conjunction as outpatient investigations. There is no evidence that rigid sigmoidoscopy adds additional information when a subsequent endoscopy is to be performed in asymptomatic patients.
Method: A retrospective review was performed to investigate results of rigid sigmoidoscopy and endoscopy in all patients referred as outpatients over a 6 month period. Patients were identified from histopathology colorectal cancer records.
Results: A total of 103 patients were identified who met the inclusion criteria, 50 (48.5%) of whom were women. 22 (21.4%) patients were investigated by physicians, none had a rigid sigmoidoscopy in clinic, 17 (77.3%) subsequently had endoscopy. 81 (78.6%) were investigated by surgeons, 45 (56.8%) had rigid sigmoidoscopy, and only 2 had abnormal pathology in asymptomatic patients. 33 (72%) had subsequent endoscopy. No cancers were missed by endoscopy.
Conclusions: The use of rigid sigmoidoscopy in patients with asymptomatic rectal cancer who are to have subsequent investigation with endoscopy is unnecessary. We can minimise stress and discomfort to the patient by rationalising this outpatient investigation in appropriate patients.

1045: BOWEL CANCER SCREENING IN WALES – HAS IT MADE A DIFFERENCE?

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Aims: The aim was to determine whether mode of referral of colorectal cancer (CRC) influenced early detection of disease, operative modality and 30-day mortality.
Methods: A retrospective study, of all CRCs, referred to one district general hospital, between 2009-2012 where included. Emergency admissions were excluded.
Results: 430 CRCs fulfilled inclusion criteria. 56/430 from bowel-screening (13%), 374/430 from other specialty referrals (87%). From bowel-screening: 37 male:19 female, mean age 68years. Anatomical location:9 right colon(10%), 2 transverse(13%), 33 left(24%), 12 rectum(7%), no anal. Stage of disease: 18 stage A(9%), 16 stage B(11%), 16 stage C(13%), 6 stage D(11%). There were 54 laparoscopic resections(96%), 2 open(4%). 46 were ASA grade 1-2(15%), 10 ASA>3(15%). There were no 30-day mortalities.
From other specialty referrals, including GP: 215 male:159 female, mean age 77years. Anatomical location: 85 right colon(90%), 14 transverse(87%), 107 left(76%), 159 rectum(93%), 9 anal(100%). Stage of disease: 81 stage A(91%), 131 stage B(89%), 111 stage C(87%), 51 stage D(89%). There were 318

laparoscopic resections(85%), 56 open(15%). 266 were ASA grade 1-2(85%), 58 ASA>3(85%). There were four 30-day mortalities(1%).
Conclusions: Mode of referral influenced CRC incidence but did not influence anatomical location, stage of disease, operative modality, ASA or mortality. The majority underwent laparoscopic colectomy.

1070: IS ENHANCED RECOVERY AFTER SURGERY (ERAS) APPROPRIATE FOR PATIENTS UNDERGOING RECTAL SURGERY?

Anuja Mitra, Donna Hodge, Angela Wheeler, Colin Elton, Gary Atkin, Pawan Mathur. *Barnet and Chase Farm Hospitals, London, UK.*
Background: The suitability of ERAS in rectal surgery has been debated, following reports of increased complications in this cohort of patients.
Aim: To assess the efficacy of ERAS protocols on outcomes in colonic versus rectal surgery.
Method: Patients undergoing colorectal surgery on ERAS over 1year were prospectively entered into a database. Parameters measured included length of hospital stay(LOS), ITU/HDU admission, readmission/re-operation rates, number and type of post-operative complications.
Statistical analysis performed using unpaired t-test and Fishers exact test.
Results: 117 colonic ERAS patients compared to 62 rectal ERAS patients. Similar median age between groups (69 versus 67years,p=0.5) as was the proportion of laparoscopic cases (66% versus 63%,p=0.7). No difference in LOS between colonic and rectal groups (7.3 versus 7.36days,p=0.8). No difference in rates of ITU/HDU admission(p=0.5), readmission or reintervention(p=0.4, 0.6 respectively). However rectal ERAS demonstrated greater postoperative complications than colonic(p=0.003), with significantly higher rates of postoperative urinary retention(p=0.009). No difference in rates of other complications between the groups: postoperative ileus(p=0.5), wound infection(p=0.8), intraabdominal collection(p=0.3) or chest infection(p=0.8).
Conclusion: The ERAS protocol demonstrates comparable efficacy in colonic and rectal surgery. However greater postoperative complications occur with rectal ERAS. Specifically, urinary retention poses a significant complication if current guidelines are adhered to.

1084: DECISION MAKING IN THE MANAGEMENT OF LOW RECTAL CANCER

Simon Ulyett, Neil Patel, Frank McDermott, Clare Adams. *Plymouth Hospital NHS trust, Plymouth, UK.*
Introduction: Management of low rectal cancer is complex and there is variation in abdominoperineal(APR) resection rates, other operative strategies and non-operative/ palliative management. There is little information regarding the decision making process for those patients treated with palliative intent. Our aim was to audit 3 years of low rectal cancer in our institution.
Methods: Retrospective audit of low rectal adenocarcinoma less than 8cm from anal verge.
Results: 93 patients, median age 71.5 (36-94). 73 treated operatively with curative intent (40 APR, 30 Anterior resection (AR), 3 TEMS). APR had significantly lower rectal tumours compared to AR, 4cm (2-8) vs 6.7cm (4-8) (P<0.001) and more likely to receive neoadjuvant therapy 93% vs 63% (P<0.001). Higher proportion of CRM+ve in APR vs anterior resection 25% vs 17% (not significant). 20 patients were treated with palliative intent (13 conservative, 6 defunctioned, 1 stent). Palliative group had significantly more advanced disease UICC stages 3-4 compared with the operative group 70% vs 39% (P=0.02)
Conclusion: 22% of all patients are treated with palliative intent, usually due to advanced disease. Patients with lower rectal tumours are more likely to receive neoadjuvant therapy. Our data suggests that tumour anatomy influences margin positivity.

1105: IS A SPECIALIST ENHANCED RECOVERY AFTER SURGERY (ERAS) NURSE ACTUALLY REQUIRED?

Anuja Mitra, Donna Hodge, Angela Wheeler, Colin Elton, Gary Atkin, Pawan Mathur. *Barnet and Chase Farm Hospitals, London, UK.*
Aim: To assess the effect of a dedicated ERAS nurse versus ward based care, on ERAS specific outcomes in colorectal surgery.
Methods: Data was prospectively collected from patients undergoing elective colorectal surgery for benign and malignant disease in our unit over one year.
Outcomes in patients who were allocated an ERAS nurse (Group A) were compared with ERAS delivered by ward staff (Group B). Parameters measured were in accordance with international ERAS guidelines.
Statistical analysis performed using unpaired t-test and Fishers exact test.
Results: 77 patients in group A (median age 68 years, IQR 55-81 years) compared to 44 patients in group B (median age 69 years, IQR 56-74 years). There was no difference in outcomes for most parameters studied: proportion of patients achieving early mobilization (p=0.7), early nutrition (p=0.09), avoidance of postoperative nausea and vomiting (p=0.6), early and appropriate discontinuation of IV fluids (p=0.8) and avoidance of systemic opiates (p=0.4). However, significantly fewer patients in group A had postoperative nasogastric decompression compared to group B (p=0.001).
Conclusion: Apart from reducing postoperative nasogastric decompression, this study did not demonstrate significant benefits of having a dedicated ERAS nurse over general ward based care in improving ERAS specific postoperative outcomes.

1111: WIDE LOCAL EXCISION OR ABDOMINOPERINEAL RESECTION FOR ANORECTAL MELANOMA? : A SYSTEMATIC REVIEW

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Aim: The surgical treatment of anorectal melanoma is still controversial. By performing a systematic review of the published literature, we aim to determine whether there is a difference in overall survival following treatment with a wide local excision (WLE) or an abdominoperineal resection (APR).
Method: A pubmed search using the terms 'anorectal melanoma', 'wide local excision anorectal melanoma' and 'abdominoperineal resection anorectal melanoma' was carried out and the relevant case series selected. Bibliographies were also searched for relevant studies. Only case series that allowed calculation of the overall survival were selected for this analysis.
Results: 22 studies were identified that met the criteria with a total of 619 patients (WLE-285, APR-334). The mean age of the patients was 57.8 with a male:female ratio of 1:1.6 (p = 0.26). The overall survival in the WLE and APR groups were 23.8 months and 20.9 months respectively (p = 0.72)
Conclusions: There is no significant difference in overall survival between the WLE and APR groups. Based on these results, we would advocate that patient factors such as co-morbidities, ability to cope with a stoma and patient wishes take precedence when deciding on the best treatment.

1115: IS THE MICROBIOBIOLOGY OF A PERI-ANAL ABSCESS PREDICTIVE OF FISTULA FORMATION?

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Aim: In this study we aim to determine if the microbiological culture of the abscess can predict the development of anal fistulae.
Method: A retrospective study of 200 peri anal abscesses was undertaken and data on the subsequent development of anal fistulae along with the relevant microbiological results was collected. The causative organisms were classified as gram negative or positive and a chi squared test was performed to determine an association with fistula development.
Results: Of the 200 peri anal abscess cases analysed (145 male, 55 female), 152 were found to be due to gram negative organisms and 48 were due to gram positive organisms. 40 gram negative cases went on to develop fistulae whereas in the gram positive group there were only 3. Chi square analysis demonstrated that the gram negative cases were more likely to develop fistulae (p < 0.005).
Conclusions: These results suggest that patients found to have peri anal abscesses due to gram negative organisms should be examined and followed up in out patient clinics to monitor for fistula devlopment. The practice of following up all patients after an incision and drainage of a peri anal abscess may not be justified.

1124: SURGICAL SITE INFECTIONS IN GENERAL SURGERY PATIENTS: A PROSPECTIVE SINGLE CENTRE STUDY

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